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Mobile Crisis Management

Service Definition and Required Components

Mobile Crisis Management involves all support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities. Mobile Crisis Management services are available at all times, 24/7/365. Crisis response provides:

- immediate evaluation
- triage
- access to acute mh/dd/sa services, treatment, and supports
- safe transition of persons in acute crises to appropriate crisis supports/services.

These services include immediate telephonic response to assess the crisis and determine the risk, mental status, medical stability, and appropriate response. Mobile Crisis Management also includes crisis prevention and supports that are designed to reduce the incidence of recurring crises. These supports and services should be specified in a recipient's Crisis Plan, which is a component of all Person Centered Plans. Mobile Crisis Management services must be delivered by a team of practitioners employed by a mental health/substance abuse/developmental disability provider organization

For more on this service definition see 1-9-06 final draft of the new and revised service definitions on Division's public website.

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Crisis Services and Standards

(excerpted from Division's Policy Guidance Development of Community-Based Crisis Stabilization Services)

Crisis services shall be designed for prevention, intervention and resolution, not merely triage and transfer,…

Currently, every person receiving enhanced services must have a crisis plan. The Community Support team who developed the crisis plan with the person is also responsible for monitoring (usually twice a month) and updating the crisis plan. The crisis plan includes identifying the first responder in any crisis event. While Community Support can be used for crisis response as medically necessary, it is the primary provider who knows the client best. Therefore, it is the primary provider who is responsible for first response to the crisis event.

Service definitions and standards have been approved by the North Carolina Division of Medical Assistance (DMA) and the Centers for Medicaid and Medicare Services (CMS) and are used here to identify those that are applicable to the provision of crisis services. See the final version of the definitions for accuracy and additional entrance criteria and service limitations.

Tables 1 and 2 present examples of relevant crisis services definitions according to responsibility by first responders or by LME. This is not an exhaustive list.

Table 1. Examples of "First Response" to crisis using proposed service definitions

Service	Description	Location
Community Support-Adults (MH/SA)	Face to face with the client.	Any location (such as home, school or homeless shelter).
Community Support-Children/ Adolescents (MH/SA)	Face to face with the client.	Any location (such as home, school or homeless shelter).
Intensive In-Home Services	Time-limited intensive family preservation intervention intended to diffuse the current crisis, evaluate its nature, and intervene to reduce the likelihood of a recurrence. Ultimately to stabilize the living arrangement, promote reunification or prevent the utilization of out-of-home therapeutic resources (i.e., psychiatric hospital, therapeutic foster care, and residential treatment facility).	Primarily delivered in the child and family's home.
Multisystemic Therapy (MST)	A program designed to enhance the skills of youth who have antisocial, aggressive/violent behaviors, are at risk of out-of-home placement due to delinquency; are adjudicated youth returning from out-of-home placement; are chronic or violent juvenile offenders, and/or are youth with serious emotional disturbances involved in the juvenile justice system.	Any location.
Community Support Team (CST) (MH/SA)	An intensive community service that provides mental health and substance abuse treatment and restorative interventions and supports necessary to achieve the rehabilitative and recovery goals of the person	Any location.
Assertive Community Treatment Team (ACTT)	A service provided by an interdisciplinary team that ensures service availability 24 hours a day, 7 days per week and is prepared to carry out a full range of treatment functions wherever and whenever needed. Access to a variety of interventions twenty-four (24) hours, seven days per week by staff that will maintain contact and intervene as one organizational unit.	
Targeted Case Management for	A service to assist individuals in gaining access to	Any location.

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Service	Description	Location
Individuals with Developmental Disabilities	and monitoring needed services and supports through development of person-centered plan and crisis plan.	
Substance Abuse Intensive Outpatient Program (SAIOP)	Structured individual and group addiction activities and services provided for recovery and recovery maintenance.	An outpatient program.
Substance Abuse Comprehensive Outpatient Treatment Program (SACOT)	A periodic service, time limited multi-faceted treatment approach emphasizing reduction in use and abuse and/or abstinence, counseling, social network development and various skills for lifestyle change.	An outpatient program.

The LME is responsible for making crisis intervention services available for new clients, for established clients without a primary provider who provides first response, and for recipient clients when the capacity of the first responder has been exceeded. The following are service definitions of services that an LME may encourage when building community capacity.

Table 2. Other crisis service definitions for building community capacity

Service	Description	Location
Mobile Crisis Management (MH/SA)	Support, services and treatments necessary to provide integrated crisis response, crisis stabilization interventions, and crisis prevention activities available 24/7/365.	Face-to-face with the consumer and in locations outside the agency's facility in the least restrictive environment and in or close to a person's home, school, work, local emergency room, etc.
Inpatient Hospital Psychiatric Treatment (MH)	An organized, licensed 24-hour service that provides intensive evaluation and treatment delivered in an acute care inpatient setting by medical and nursing professionals under the supervision of a psychiatrist. This service is designed to provide continuous treatment for individuals with acute psychiatric problems.	Community hospital psychiatric unit. Also applies to use of the regional state psychiatric hospital through bed day allocation.
Facility based Crisis Intervention	An alternative to hospitalization in a 24-hour residential facility that provides support and crisis services in a community setting. Can be provided in a non-hospital setting for recipients in crisis who need short term intensive evaluation, treatment intervention or behavioral management to stabilize acute or crisis situations.	A licensed facility 10 NCAC 14V.5000.
Social Setting Detoxification	A clinically managed residential detoxification program with 24-hour supervision.	At the licensed facility 10A NCAC 14V.3200.
Non-Hospital Medical Detoxification	An organized service with 24-hour medical supervision.	At a licensed facility 10A NCAC 27G.3100.
Medically Supervised or ADATC Detoxification/ Crisis Stabilization	24-hour medically supervised evaluation and withdrawal management providing short term intensive evaluation, treatment intervention or behavioral management to stabilize the acute or crisis situation.	A permanent facility with inpatient beds.

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APPENDIX B

MODELS OF MOBILE CRISIS SERVICES

While we realize these models are not identical to the model we are implementing in North Carolina, the process of the development of this rural service and state-wide service can serve as an example of how to think about these issues.

Kentucky has demonstrated that mobile crisis can be successfully provided in rural areas with designated staff on call in each county and when facility based crisis units or other services may be too far away and not timely. Kentucky's mobile crisis units (with specifics from the Kentucky River Region) are built to work in rural regions. In the Kentucky River Region (that covers 8 counties), there is a toll-free crisis line that responds to calls mainly in the evenings, holidays and weekends. The crisis line operator has a list of clinicians that are "on call" for that particular day. These clinicians are paid a flat fee to carry the pager and be on call, and they are paid an additional "per assessment" fee for each crisis event. The staff is spread across the counties of the region. Each county has a designated site where staff meets the youth/family at a medical hospital or a mental health facility. Consequently, the family travels only a short distance to be seen for assessment. If they need crisis stabilization or hospitalization, the staff ensures that the family can safely transport the child/youth. Occasionally, a judge will sign a transport order if the family needs that, but most of the time the family can get there. There are also on-call staff paid by the hour to drive an agency vehicle to transport the youth with the parent/guardian. There are some staff who are willing to go into the home to assist families, but that is on a case by case basis and is usually established as a part of their crisis plan. The outpatient staff in each county is trained to respond to crises in their communities during the work hours so there should never be a time that a responder is that far away.

Connecticut

Connecticut is one of few states that provides mobile crisis services State-wide for adults and children throughout its four regions. There are 16 mobile crisis teams of mental health workers (Psychiatrist, RNs, MSWs, psychologists, and psychiatric technicians) who intervene in situations where an individuals mental or emotional condition results in behavior which constitutes an imminent danger to him or herself or to another person. These mobile crisis teams visit people in their homes or community sites or meet them in clinics or hospital emergency rooms. The Department of Children and Families provides these crisis services for children through a "System of Care" network funded by the agency's Connecticut Community Kidcare Initiative. The Connecticut Department of Mental Health and Addiction Services provides the same type of service for adults through the local mental health authorities.

Department of Mental Health and Addiction Services (DMHAS) http://www.dmhas.state.ct.us/crisisservices.htm
Department of Children and Families (DCF) http://www.state.ct.us/dcf/KidCare_Directory/Kidcare_index.htm

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Geller, J. L., Fisher, W. H., & McDermit, M. (1995). A national survey of mobile crises services and their evaluation. *Psychiatric Services*, 46 (9), 893-897.

Guo, S., Beigel, D., Johnsen, J., & Dyches, H. (2001) Assessing the impact of community based mobile crisis services on preventing hospitalization. *Psychiatric Services 52(2)*, 223-228.

Hatcher, S., O'Brien, T., Coupe, N., & Charters, G. (2003). *Effective models of crisis mental health service delivery.* The Division of Mental Health Research & Development Strategy.

Jackson, E., (2005) A community-based comprehensive psychiatric crisis response service: An informational and instructional monograph. Technical Assistance Collaborative, Incorporated.

North Carolina Divisions of Medical Assistance & Mental Health, Developmental Disabilities, and Substance Abuse Services (2005) *Draft Service Definitions and Standards*.

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North Carolina Division of Mental Health, Developmental Disabilities, and Substance abuse Services (2005). *Communication Bulletin #48: Mobile Crisis Management.*

United States Department of Health and Human Services (1999). *Mental Health: A Report of the Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, National Institute of Health, National Institute of Mental Health.

Abstracts related to Mobile Crisis Management

(Excerpted from the National Library of Medicine, PubMed)

J Nerv Ment Dis. 1993 Dec;181(12):757-62.

The cost effectiveness of crisis intervention. Admission diversion savings can offset the high cost of service.

Bengelsdorf H, **Church JO**, **Kaye RA**, **Orlowski B**, **Alden DC**.

Department of Psychiatry, New York Medical College, Westchester County Medical Center, Valhalla 10595.

The authors sought to determine whether a mobile crisis intervention service can effect cost savings by diverting patients from hospital admission into community-based treatment. They followed 50 consenting adult psychiatric patients for 6 months from the first day they were seen by the crisis intervention service. At the first visit, the crisis team obtained data to assess each patient's degree of risk for hospitalization. Investigators then kept a day-by-day record of every psychiatric treatment received by each patient, in an effort to determine the cost effectiveness of crisis intervention. The authors present evidence that crisis intervention permits some patients who would otherwise have been hospitalized to remain in the community and that savings thus realized exceed the expense of crisis intervention.

:Hosp Community Psychiatry. 1993 Jan;44(1):16-7.

Benefits of mobile crisis programs.

Zealberg JJ, **Santos AB**, **Fisher RK**.

Department of psychiatry and behavioral sciences, Medical University of South Carolina, Charleston 29425.

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Hosp Community Psychiatry. 1992 Jun;43(6):612-5.

A mobile crisis program: collaboration between emergency psychiatric services and police.

Zealberg JJ, **Christie SD**, **Puckett JA**, **McAlhany D**, **Durban M**.

Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina (MUSC), Charleston 29425.

An emergency psychiatry-mobile crisis program was established in 1987 in Charleston, South Carolina, linking professionals from the mental health center, the university, and the local police department. The program has two goals: to provide emergency psychiatric services to persons in the community and to train psychiatric residents in crisis intervention. Mental health staff act as consultants to the police in some situations, and in others the police provide security. The authors describe the development of the collaboration with police and important features of the program. Three cases illustrate how such collaboration can be of mutual benefit and can save lives.

Psychiatr Serv. 1995 Sep;46(9):893-7.

A national survey of mobile crisis services and their evaluation.

Geller JL, **Fisher WH**, **McDermeit M**.

Department of Psychiatry, University of Massachusetts Medical School, Worcester 01655, USA.

OBJECTIVE: Although mobile crisis services have been widely accepted as an effective approach to emergency service delivery, no systematic studies have documented the prevalence or effectiveness of these services. This survey gathered national data on the use and evaluation of mobile crisis services. METHODS: In 1993 mental health agencies in 50 states, the District of Columbia, and U.S. territories were surveyed. Repeated follow-up was done to ensure a 100 percent response. RESULTS: A total of 39 states have implemented mobile crisis services, dispatching teams to a range of settings. Although respondents reported that use of mobile crisis services is associated with favorable outcomes for patients and families and with lower hospitalization rates, the survey found that few service systems collect evaluative data on the effectiveness of these services. CONCLUSIONS: The claims of efficacy made for mobile crisis services, which have led to their widespread dissemination, are based on little or no empirical evidence. More rigorous evaluation of new and existing modes of service delivery is needed. The need for such evaluation will increase in the climate promulgated by managed care, in which greater emphasis is placed on cost-effectiveness.

Psychiatr Serv. 2001 Feb;52(2):223-8.

Assessing the impact of community-based mobile crisis services on preventing hospitalization.

Guo S, **Biegel DE**, **Johnsen JA**, **Dyches H**.

College of Social Work, University of Tennessee, Memphis, USA.

OBJECTIVE: This study evaluated the impact of a community-based mobile crisis intervention program on the rate and timing of hospitalization. It also explored major consumer characteristics related to the likelihood of hospitalization. METHODS: A quasi-experimental design with an ex post matched control group was used. A community-based mobile crisis intervention cohort (N=1,696) was matched with a hospital-based intervention cohort (N=4,106) on seven variables: gender, race, age at the time of crisis service, primary diagnosis, recency of prior use of services, indication of substance abuse, and severe mental disability certification status. The matching process resulted in a treatment group and a comparison group, each consisting of 1,100 subjects. Differences in hospitalization rate and timing between the two groups were assessed with a Cox proportional hazards model. RESULTS: The community-based crisis intervention reduced the hospitalization rate by 8 percentage points. A consumer using a hospital-based intervention was 51 percent more likely than one using community-based mobile crisis services to be hospitalized within the 30 days after the crisis (p<.001). Treating a greater proportion of clients in the community rather than hospitalizing them did not increase the risk of subsequent hospitalization. Those most likely to be hospitalized were young, homeless, and experiencing acute problems; they were referred by psychiatric hospitals, the legal system, or other treatment facilities; they showed signs of substance abuse, had no income, and were severely mentally disabled. CONCLUSIONS: Results indicate that community-based mobile crisis services resulted in a lower rate of hospitalization than hospital-based interventions. Consumer characteristics were also associated with the risk of hospitalization.

Aust N Z J Psychiatry. 2002 Aug;36(4):504-8. =

A comparison in hospitalization rates between a community-based mobile emergency service and a hospital-based emergency service.

Hugo M, **Smout M**, **Bannister J**.

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OBJECTIVES: The aims of this study were to compare the rates of inpatient admission between a mobile community-based psychiatric emergency service and a hospital-based psychiatric emergency service, and to identify the clinical characteristics of consumers more likely to be admitted to hospital. METHODS: A retrospective, quasi-experimental design was used with a 3-month cohort of all face-to-face emergency service contacts presenting at the mobile and hospital-based sites. The Health of the Nation Outcome Scales and details of the outcome following initial assessment were completed for all contacts, and each group was compared for differences in clinical characteristics and outcome. RESULTS: Hospital-based emergency service contacts were found to be more than three times as likely to be admitted to a psychiatric inpatient unit when compared with those using a mobile community-based emergency service, regardless of their clinical characteristics. Those with severe mental health disorders such as schizophrenia and major affective disorder, and experiencing problems with aggression, non-accidental self-injury, hallucinations and delusions, problems with occupation, activities of daily living, and living conditions were more likely to be admitted to hospital. Nevertheless, after controlling for clinical characteristics, site of initial assessment accounted for a substantial proportion of the variance in decisions to admit to hospital. CONCLUSIONS: Emergency psychiatric services which include a mobile component and provide a specialized multidisciplinary team approach appear to be most effective in providing services in the least restrictive environment and avoiding hospitalization.

Psychiatr Serv. 2000 Sep;51(9):1153-6.

Evaluation of a mobile crisis program: effectiveness, efficiency, and consumer satisfaction.

Scott RL.

Georgia Mountains Community Services, Gainesville 30501, USA.

OBJECTIVE: The effectiveness and efficiency of a mobile crisis program in handling 911 calls identified as psychiatric emergencies were evaluated, and the satisfaction of consumers and police officers with the program was rated. METHODS: The study retrospectively examined differences in subjects' demographic characteristics, hospitalization and arrest rates, and costs for 73 psychiatric emergency situations handled by a mobile crisis team and 58 psychiatric emergency situations handled by regular police intervention during three months in 1995. Consumers' and police officers' satisfaction with the mobile crisis program was evaluated through Likert-type scales. RESULTS: Fifty-five percent of the emergencies handled by the mobile crisis team were managed without psychiatric hospitalization of the person in crisis, compared with 28 percent of the emergencies handled by regular police intervention, a statistically significant difference. The difference in arrest rates for persons handled by the two groups was not statistically significant. The average cost per case was 23 percent less for persons served by the mobile crisis team. Both consumers and police officers gave positive ratings to the mobile crisis program. CONCLUSIONS: Mobile crisis programs can decrease hospitalization rates for persons in crisis and can provide cost-effective psychiatric emergency services that are favorably perceived by consumers and police officers.

Ment Retard. 1998 Jun;36(3):187-97.

Evaluation of outcomes and cost-effectiveness of a community behavioral support and crisis response demonstration project.

Rudolph C, **Lakin KC**, **Oslund JM**, **Larson W**.

Research and Training Center on Community Living/Institute on Community Integration, University of Minnesota, Minneapolis 55455, USA.

A behavioral support and crisis response demonstration project authorized by the Minnesota Legislature in 1992 was evaluated. We described the demonstration program, its service users, and satisfaction and concerns with the program of service recipients, their families and careproviders, and county case managers. We also provided follow-up data on the outcomes of the first year service users and gave the service outcomes projected by case managers had the program not been established. These projected outcomes were validated by follow-up of a comparison group of persons unable to access the program's services. Cost-effectiveness was computed from costs of establishing and operating the demonstration program and the actual average costs of the services that were projected to otherwise have been used.

New Dir Ment Health Serv. 1999 Summer;(82):93-9.

Mobile crisis: moving emergency psychiatry out of the hospital setting.

Alexander C, **Zealberg JJ**.

Medical University of South Carolina, Charleston, USA.

Mobile crisis teams constitute a growing force in emergency psychiatric service provision in the community. The implications of the for-profit, private teams that are joining the long-standing public teams are discussed.

Psychiatr Serv. 1998 Mar;49(3):301-3.

Mental health clinicians' role in responding to critical incidents in the community.

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Zealberg JJ, **Hardesty SJ**, **Tyson SC**.

Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, Charleston 29425, USA.

1: Hosp Community Psychiatry. 1990 Jul;41(7):804-5.

Whom do mobile crisis services serve?

Gillig P, **Dumaine M**, **Hillard JR**.

Wright State University School of Medicine, Dayton, OH 45401.